FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **State of Washington**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): CHIP (Children's Health Insurance Program)

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
X Separate Child Health Program Only
_____ Combination of the above

Reporting Period: ***Federal Fiscal Year 2003*** *Note: Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03.*

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Submission Date: **January 26, 2004**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	Over 0% FPL	% of FPL conception to birth	Up to and including 185% FPL	% of FPL
	From		% of FPL for **infants**		% of FPL	From	Over 200% FPL	% of FPL for **infants**	Up to and including 250% FPL	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	From	Over 200% FPL	% of FPL for 1 **through 5**	Up to and including 250% of FPL	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	From	Over 200% FPL	% of FPL for children ages **6 through 16**	Up to and including 250% of FPL	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	From	Over 200% FPL	% of FPL for children ages **17 and 18**	Up to and including 250% of FPL	% of FPL

Is presumptive eligibility provided for children?		No		No X
		Yes, for whom and how long?		Yes, for whom and how long?

Is retroactive eligibility available?		No		No
		Yes, for whom and how long?		Yes, for whom and how long? Yes, retroactive coverage is available *only* for our population of unborn children. Retroactive eligibility for the unborn can be up to 3 months from the time of application but no further than conception.

Does your State Plan contain authority to implement a waiting list?	Not applicable		No X
			Yes

Does your program have a mail-in application?		No		No
		Yes		Yes X

Can an applicant apply for your program over phone?		No		No
		Yes		Yes X An applicant can provide initial information over the phone, but must still provide documentation and signature in order for the application to be complete.

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
		Yes		Yes X

Can an applicant apply for your program on-line?		No		No	
	Yes – please check all that apply			Yes – please check all that apply X	
		Signature page must be printed and mailed in		X	Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)		X	Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required			Electronic signature is required
					No Signature is required

Does your program require a face-to-face interview during initial application		No		No X
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No		No	
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6		Yes X Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6	
	specify number of months		specify number of months		4 months, with exceptions listed in Section III, subsection Substitution of Coverage, question 6

Does your program provides period of continuous coverage <u>regardless of income changes?</u>		No		No X As of July 1, 2003, continuous eligibility was rescinded by the Washington State Legislature
		Yes		Yes
	specify number of months		specify number of months	
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	

Does your program require premiums or an enrollment fee?		No		No
		Yes		Yes X
	Enrollment fee amount		Enrollment fee amount	N/A
	Premium amount		Premium amount	$10 per child per month, with a maximum premium amount of $30 per family per month
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below	

Does your program impose copayments or coinsurance?		No		No X
		Yes		Yes

Does your program require an assets test?		No		No X
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	

Is a preprinted renewal form sent prior to eligibility expiring?		No		No
	Yes, we send out form to family with their information precompleted and		Yes, we send out form to family with their information precompleted and	
		we send out form to family with their information pre-completed and ask for confirmation	X	we send out form to family with their information pre-completed and ask for confirmation
		we send out form but do not require a response unless income or other circumstances have changed		we send out form but do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? [X] Yes [ ] No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? [X] Yes [ ] No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				x
b) Application				x
c) Benefit structure				x
d) Cost sharing structure				x
e) Cost sharing collection process				
f) Crowd out policies				x
g) Delivery system				x
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				x
i) Eligibility levels / target population				x
j) Eligibility redetermination process			x	
k) Enrollment process for health plan selection			x	
l) Family coverage				x
m) Outreach (e.g., decrease funds, target outreach)				X
n) Premium assistance				x
o) Prenatal Eligibility expansion			x	

p) Waiver populations (funded under title XXI)

Parents

Pregnant women

Childless adults

q) Other – please specify

a. _____

b. _____

c. _____

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing structure or e) Cost Sharing collection process (separate?)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
i) Eligibility levels / target population	
j) Eligibility redetermination process	We now use a pre-printed eligibility renewal form. Clients need to review and update the information on the renewal form and return it with documentation of current income every six months.
k) Enrollment process for health plan selection	CHIP clients have been integrated into an automated enrollment process for health plan selection. As soon as a client is determined eligible for CHIP, they are automatically sent a letter and a Healthy Options booklet that outlines options for health care plans in their

	county of residence. An eligibility worker no longer has to manually send out a managed care enrollment packet to the client.
l) Family coverage	
m) Outreach	
n) Premium assistance	
o) Prenatal Eligibility Expansion	A state plan amendment for prenatal eligibility expansion was approved by CMS on September 22, 2003.
p) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
q) Other – please specify	
a.	
b.	
c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program and if the strategic objective listed is new/revised or continuing.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Please include the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
New/revised _____ Continuing __X__ To reduce the percentage of uninsured children between 200% and 250% FPL.	Reduce the percentage of uninsured children between 200% and 250% FPL.	Data Sources: Washington State Population Survey (WSPS) Methodology: Tracking the percentage of uninsured children between 200% and 250% FPL. Progress summary: In 2000, the percentage of uninsured was 6.9%. In the 2002 survey, the percentage of uninsured was 7.8%. This is a slight increase from the previous survey of +0.9%.
Objectives Related to SCHIP Enrollment		
New/revised _____ Continuing __X__ To increase the number of children in households between 200% and 250% FPL who have health insurance coverage.	Increase the number of children between 200% and 250% who have health care coverage.	Data Sources: WSPS Methodology: Tracking the number of children in households between 200% and 250% FPL with health insurance coverage. Progress summary: In 2000, the estimated number of children between 200% and 250% FPL with health insurance was 127,028 (93.1%). In 2002, the estimated number with health insurance was 113,069 (92.2%).
Objectives Related to Increasing Medicaid Enrollment		
New/revised _____ Continuing __X__ To increase the number of low-income children in households below 200% of the FPL who have health insurance coverage.	Increase the number of children below 200% FPL who have health coverage. Increase the percentage of children below 200% FPL who have health coverage.	Data Sources: WSPS Methodology: Tracking the number of children with health insurance in households below 200% FPL. Progress summary: In 2000, the estimated number of children in households below 200% FPL with health insurance was 531,347 (90.9%). In 2002, the number of children with health insurance was 607,232 (93.8%). This shows an increase of 2.9% for insured children below 200% FPL.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised _____ Continuing _____		Data Sources: Methodology: Progress summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
New/revised _____ Continuing __**X**___	Track the satisfaction and health care of SCHIP children compared to Medicaid children and non-Medicaid children.	Data Sources: CAHPS, EPSDT chart review study, HEDIS Methodology: Progress summary: A CAHPS study was last completed in 2002 and the results were reported in the 2002 SCHIP Annual Report. The next CAHPS study will be in 2004. An EPSDT study was conducted in 2002 and results were reported in the 2002 SCHIP Annual Report. Another EPSDT chart review study will be completed in 2005. The most current HEDIS report was conducted in 2003; results are detailed below.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

We measure access primarily through the CAHPS survey, through EPSDT chart review studies, and through HEDIS. We last conducted a CAHPS survey and an EPSDT chart review study in 2002. The results from each were reported in last year's annual report.

HEDIS is collected for SCHIP and Medicaid, but the results are not separated out by population. At this time, the sample size for SCHIP is too small for meaningful analysis. Our latest HEDIS report was conducted in 2003. A summary included in our 2003 HEDIS report includes the following statement:

"All Washington health plans improved on at least two measures in 2002 and the statewide median rate increased on six measures. All health plans improved every childhood immunization measure except DtaP (which is likely due to vaccine shortage), and nearly all health plans are getting better on most measures over time. Over the four-year period from 1999 to 2002, every health plan improved the prenatal care rate and five were statistically significant. There is, nevertheless, opportunity for higher achievement."

The entire 2003 HEDIS Report is included as an attachment to this Annual Report.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

Washington State will continue to measure SCHIP using EPSDT and CAHPS. In 2004, MAA plans to survey SCHIP children using the CAHPS survey; in 2005 MAA plans to conduct the EPSDT chart review study and again examine both the quantity and quality of well-child care.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

We have not conducted any additional reports since we submitted our 2002 Annual Report.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

- Attachment A: 2003 HEDIS Report

Reporting of National Performance Measures

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. ***If your State currently has data on any of these measures***, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Measure	**Describe how it is measured**	
Well child visits for children in the first 15 months of life	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tool Progress Summary: Data collection began in 2003
Well child visits in the 3rd, 4th, 5th, and 6th years of life	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: Data collection began in 2003
Use of appropriate medications for children with asthma	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: Data collection began in 2003
Comprehensive diabetes care (hemoglobin A1c tests)	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: Data has been collected on alternate years beginning in 2000
Children's access to primary care services	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: Initial data collection began in 2003

Adult access to preventive/ambulatory health services	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: Data collection began in 2003
Prenatal and postpartum care (prenatal visits)	HEDIS	Data Sources: Managed care health plans Methodology: HEDIS data submission tools Progress Summary: We have collected 4 years of data. A copy of our most current HEDIS Report is included as an attachment to this Annual Report.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

_____ SCHIP Medicaid Expansion Program (SEDS form 64.21E)

9,571 Separate Child Health Program (SEDS form 21E)

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

Washington has used its biennial Washington State Population Survey (WSPS) to make its baseline estimates. We will continue to use this source to measure subsequent changes in the number and percentage of children who have insurance coverage over time. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Study (CPS). However, the survey is a statewide survey with a greatly enhanced sample size to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socioeconomic characteristics of people of different racial and ethnic backgrounds.

In the 2000 WSPS, it was estimated that there were 1,615,132 children 0-18 years of age of all income levels living in Washington State. It is estimated that 89,480 (5.5%) of these children did not have health insurance.

In the 2002 WSPS, it was estimated that there were 1,629,381 children 0-18 years of age of all income levels. An estimated 73,325 (4.5%) did not have health insurance. This shows a percentage decrease of 1.0% in the number of uninsured children.

Survey Year	Total # of Children **(All Income Levels)**	Total # Insured	Total # Uninsured	Total % Uninsured	Percentage Point Change in Uninsured from Previous Survey
2000	1,615,132	1,525,652	89,480	5.5%	N/A
2002	1,629,381	1,556,056	73,325	4.5%	-1.0%

For all low-income children within both Medicaid and SCHIP income levels (0-250% FPL), the percentage of children without health insurance decreased from 8.7% in the 2000 WSPS to 6.5% in the 2002 WSPS. This shows a decrease of 2.2 percentage points in the number of uninsured low-income children over the two-year survey period.

The Table below details the population of insured and uninsured in all low-income households (0–250% FPL).

Survey Year	Total # of Children **(0 – 250% FPL)**	Total # Insured	Total # Uninsured	Total % of Uninsured	Percentage Point change in Uninsured from Previous Survey
2000	720,805	658,375	62,430	8.7%	N/A
2002	769,989	720,301	49,688	6.5%	-2.2%

Of the 122,570 children whose household income level falls within SCHIP income levels (200-250% FPL), there were 9,501 (7.8%) estimated to be uninsured at the time of the 2002 WSPS. In the 2000 WSPS, it was estimated that 9,343 children (6.9%) out of 136,371 SCHIP eligible children were uninsured. This shows an increase of 0.9 percentage points over a two-year period in the number of SCHIP eligible children who are without insurance.

The Table below details the population of insured and uninsured children within SCHIP income levels (200-250% FPL).

Survey Year	Total # of Children **(200-250% FPL)**	Total # Insured	Total # Uninsured	Total % of Uninsured	Percentage Point Change in Uninsured from Previous Survey
2000	136,371	127,028	9,343	6.9%	N/A
2002	122,570	113,069	9,501	7.8%	+0.9%

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

We do not have a direct count of the effects of the different types of outreach on the number of children enrolled in Medicaid and SCHIP. However, the number of children currently enrolled shows our state's commitment to outreach efforts.

For example, on September 30, 2002, we had 561,789 children enrolled in Medicaid and SCHIP medical program categories. As of September 30, 2003, we had a total of 570,448 children enrolled. This is an increase of 8,659 children, or 1.5%.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

   ____ No, skip to the Outreach subsection, below

   X Yes, please provide your new baseline ____ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

_____ The March supplement to the Current Population Survey (CPS)

__X__ A State-specific survey - **Washington State Population Survey (WSPS)**

_____ A statistically adjusted CPS

_____ Another appropriate source

A. What was the justification for adopting a different methodology?

Please refer to **Attachment B**: 2002 Washington State Population Survey Research Brief No. 20, June 2003, Accounting for Medicare and Medicaid Recipients, for a detailed explanation of the methodology used and justification for adopting a different methodology.

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

Please refer to **Attachment B**: 2002 Washington State Population Survey Research Brief No. 20, June 2003, Accounting for Medicare and Medicaid Recipients, for a detailed explanation of the reliability and limitation of the data and estimation methodology.

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

For this 2003 Annual Report, we adjusted our WSPS data for the year 2000 using the new methodology in order to make it comparable to the 2002 WSPS data.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

Our outreach strategies have not changed during this reporting period. Our advocates and community partners continue to be our strongest link to providing outreach and information to our children's populations.

Our commitment to our Healthy Kids Now! public awareness campaign continues. The campaign was launched in February 2000 when SCHIP was implemented in our state. The Healthy Kids Now! Campaign is aimed at families who are eligible for any of the state's children's medical programs. Through this campaign we have a toll-free number that families can call to get more information and assistance with applying for medical coverage.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Our most effective outreach continues to be our community-based partners. We work closely with a statewide outreach coalition of state and local entities. This group meets quarterly and shares best practices and program changes or updates. We also continue to partner with the statewide Title 1 Migrant Education Program who in turn partners with school nurses, records clerks, home visitors, and minorities, immigrants and rural populations. Many of these have staff that are bilingual and/or bicultural to assist clients.

We continue to have a Statewide Health Insurance Benefits Advisors (SHIBA) toll-free assistance line that provides information on the different medical programs available throughout the state.

Our rack cards and applications are printed in eight languages, including Spanish, Vietnamese, Russian, Cambodian, Korean, Laotian and Chinese. We also print the application in other languages as the need arises.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

We do not have a direct count of the effects of outreach activities on the number of children enrolled in Medicaid and SCHIP. However, the increase in the number of enrolled children is a measure of our successful outreach efforts.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. Describe how substitution of coverage is monitored and measured.

We monitor and measure substitution of coverage both through the eligibility process and through data collection. We are careful to prevent substitution of coverage from occurring both at the time of initial application and any subsequent eligibility reviews. When we receive an application or review we require that questions regarding any other insurance coverage are answered prior to eligibility approval. We ask the following questions on the initial application:

- Do any of the children you are applying for already have health insurance coverage?
- If "Yes", does that health insurance cover doctor, hospital, x-ray (radiology), and laboratory services?
- Have your children been covered by job-related health insurance in the last 4 months?
- If "Yes" did the premium cost less than $50 per month for dependents?
- If you checked "Yes" to any of the above questions, please list the name of the insurance company or employer providing health insurance for your children.

On the 6-month eligibility review form, the following questions are asked with a request to check any boxes that apply and complete the insurance information:

- I now have private health insurance or health insurance through my employer
- My private health insurance or employer provided health insurance includes coverage for doctors, hospital, x-ray and lab services
- I had job-related health insurance in the last 4 months but am no longer covered

If the insurance questions on the application or eligibility review are not answered, the applicant is sent an "Insurance Information Request Letter" that they must respond to in order for CHIP eligibility to be determined. If the applicant has access to health insurance coverage, they are not enrolled in CHIP.

Eligibility staff also utilize our Medicaid Management Information System both at initial application and eligibility review to see if there is any history of insurance coverage for the household. If there is history showing, further inquiries can be made.

To monitor substitution of coverage, the State tracks responses on the number of applications and eligibility reviews that show the applicant has insurance coverage. We also track the number of applications and eligibility reviews that are denied due to insurance coverage.

The state also tracks whether the applicant has disenrolled from employer-sponsored coverage. If the applicant has lost employer-sponsored insurance coverage within the past 4 months, the child must serve a four-month waiting period. However, prior to imposing a waiting period, we look at whether one of nine exceptions applies to the family's situation. Exceptions to the four-month waiting period may be granted when:

1) Parent lost job that has medical coverage for children.
2) Parent with medical insurance died.

3) Child has a medical condition that, without medical care, would cause serious disability, loss of function or death.
4) Employer ended medical coverage for children.
5) Child's medical coverage ended because the child reached the maximum lifetime coverage amount.
6) Coverage under a COBRA extension period ended.
7) Children could not get medical services locally (they have to travel to another city or state to get care for their children).
8) Domestic violence led to loss of coverage.
9) The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more.

If none of these exceptions apply, the child must serve a four-month waiting period prior to enrollment in CHIP.

We do not impose a waiting period on those families who drop private insurance that is not employer related.

We also receive a monthly report of currently eligible CHIP clients who have health insurance coverage showing in our Medicaid Management Information System. MAA researches this report for current health insurance coverage to ensure there is no substitution of coverage at either initial eligibility determination or eligibility review.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

Data collected from October 2002 through September 2003 showed that approximately 4.9% of initial applicants and those completing eligibility reviews had dropped employer sponsored coverage during the prior four months and would potentially be subject to a four-month waiting period. The table shown below in Question 3 summarizes this data.

3. At the time of application, what percent of applicants are found to have insurance?

We collected data from October 2002 through September 2003 on applications and eligibility reviews to track how many applicants reported having insurance coverage. We show that 2.4% of applications and reviews reported that the applicant had health insurance coverage that would be classified as creditable coverage. We also tracked how many applications and eligibility reviews were found to have insurance and were denied for insurance coverage that would be considered creditable coverage. We denied 2.9% of our applicants for having creditable coverage.

Decision Date	Total Applications	# Dropped Insurance Coverage within 4 months of application	%	# Applications that show client has creditable coverage	%	# Applications denied for creditable coverage	**%**
October 2002	281	8	2.9	2	0.7	3	1.1
November 2002	136	8	5.6	10	13.6	2	1.5
December 2002	242	19	7.9	11	4.6	4	1.7
January 2003	241	14	5.8	4	1.7	10	4.2
February 2003	375	13	3.5	7	1.9	13	3.5

March 2003	498	29	5.8	0	0	22	4.4
April 2003	401	24	6.0	3	0.8	11	2.7
May 2003	293	10	3.4	2	0.7	8	2.7
June 2003	212	10	4.7	2	0.9	7	3.3
July 2003	269	9	3.4	4	1.5	7	2.6
August 2003	239	14	5.9	3	1.3	8	3.4
September 2003	242	17	7.0	2	0.8	8	3.3
Average	**286**	**14.6**	**4.9%**	**4.2**	**2.4%**	**8.6**	**2.9%**

States with separate child health programs over 200% of FPL must complete question 4

4. Identify your substitution prevention provisions (waiting periods, etc.).

We have a four-month waiting period for those who drop employer-sponsored or job-related coverage. We have nine exceptions to the waiting period that we review prior to imposing the waiting period. These exceptions are listed in the response to Question # 6 below.

We use our Medicaid Management Information System (MMIS) to research potential healthcare coverage. If an applicant is known to our system, we look in MMIS to see whether or not we have a prior history of coverage. If a prior history is shown, we can do further research to find out whether there is current coverage. We do find that a few applicants currently have coverage. Some of the applications and eligibility reviews do not have a response to the insurance questions; these are pended for more information. We also have a monthly report that is received in our Third Party Recovery section. This report is researched each month to find any additional clients that have coverage.

Through all these methods we are able to ensure that our state has procedures in place that will not allow for substitution of coverage.

States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

Prior to determining SCHIP eligibility, we determine whether the applicant currently has or had employer sponsored or job-related insurance within the prior 4-month period. We then look to see whether an exception to the 4-month waiting period applies in the applicant's individual case.

States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

We have the following nine exceptions to our 4-month waiting period requirement:

1. Parent lost job that has medical coverage for children
2. Parent with medical insurance died.
3. Child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
4. Employer ended medical coverage for children.
5. Child's medical coverage ended because the client reached the maximum lifetime coverage amount.
6. Coverage under a COBRA extension period expired.

7. Children could not get medical services locally (they have to travel to another city or state to get care).
8. Domestic violence led to loss of coverage.
9. The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

Yes. For both populations, a pre-populated eligibility review is automatically generated and mailed out to the client approximately six weeks prior to the eligibility review date. The eligibility review must be completed and returned along with documentation of income.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

Children on Medicaid and SCHIP have a 6-month certification period. A client must report any changes in circumstances that occur during the 6-month certification. Once a change is reported, an eligibility worker reviews the information and requests any necessary documentation. Once documentation is received, the worker enters the information into the Automated Client Eligibility System (ACES). The system automatically reviews first for Medicaid eligibility, then SCHIP eligibility. If the medical program changes based on this new information, a letter is sent from ACES informing the client of the change. If there are no changes during the 6-month certification, the client's eligibility will be reviewed when the certification period is up and the eligibility review form is received. If no eligibility review is received, the client is disenrolled from coverage and a letter of termination is sent.

Each year when the Federal Poverty Level is adjusted, we code our ACES system with the new information. ACES then conducts an automatic review to determine if the SCHIP client is within Medicaid income levels. If they are Medicaid eligible, there is an automatic transfer to that program. The client retains their original eligibility review cycle, so eligibility determination will occur again at their scheduled review.

We have not identified any challenges to this process of eligibility determination. We did make a significant change this past year due to a Legislative mandate. Prior to July 2003, we had a 12-month continuous eligibility period for all children's programs. In July, we implemented a 6-month certification period where changes in circumstance can affect eligibility. This certification change has not been in effect long enough to determine whether there will be any unanticipated challenges. However, we do have several ways of verifying income that will provide assurance that a client is determined eligible for the correct program when any changes occur.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes. We utilize the same delivery systems for both Medicaid and SCHIP. A provider who signs a Core Provider Agreement with the Medical Assistance Administration can see both Medicaid and SCHIP clients. The contract with our managed care plans is for both Medicaid and SCHIP. Both SCHIP and Medicaid clients are required to enroll in a managed care plan if there are two or more plans contracted in their area. If a client in a "mandatory" county does not choose a plan, MAA assigns them to a plan.

The managed care system consists of contracts with health carriers for medical coverage, contracts with Regional Support Networks for mental health care, and fee-for-service for primary care case management clinics. Other Medicaid and SCHIP services are "carved out" of managed care and provided on a "wrap-around" fee-for-service basis. These services include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, pregnancy terminations, interpreter services, and non-emergent transportation.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

____ Follow-up by caseworkers/outreach workers

____ Renewal reminder notices to all families, *specify how many notices and when notified*

_____

____ Targeted mailing to selected populations, *specify population* _____

____ Information campaigns

____ Simplification of re-enrollment process, *please describe* _____

____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* _____

X We send clients a "warning" notice when they are close to being disenrolled due to non-payment of SCHIP premiums. SCHIP clients are disenrolled from the program once they become 120 days overdue. When a client becomes 90 days overdue, they are sent a notice that warns them of potential disenrollment. The warning notice gives them a toll-free number to call to let us know if they no longer need SCHIP, if they have other insurance or their income has gone down.

____ Other, *please explain*

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

As our rate of disenrollment for non-payment of premiums is quite low, we believe our 90-day notice is very effective. We disenroll an average of less than 1% of clients for non-payment. To obtain this data, we track how many clients are sent a termination letter at 120 days of non-payment. The chart below details this data.

Date	Total # of Clients	Total Disenrolled for Non-Payment	Percentage of Total
Oct. 2002	7271	45	0.6
Nov. 2002	7370	97	1.3
Dec. 2002	7414	34	0.5
Jan. 2003	7307	62	0.8
Feb. 2003	7313	94	1.3
March 2003	7042	75	1.1
April 2003	7116	35	0.5
May 2003	7153	34	0.5
June 2003	7184	39	0.5
July 2003	7319	42	0.6

Aug. 2003	7435	73	1.0
Sept. 2003	8113	46	0.6
Monthly Average % Disenrolled			**0.8%**

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or move? If so, describe the data source and method used to derive this information.

We do track data on the reasons why SCHIP children disenroll. However, there was an error in our data collection during the reporting year, and we are in the process of running the data again. We expect to have a full year of data for our 2004 Annual Report.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

We have not done a specific assessment of the effects of premiums on participation. However, we track the number of households with overdue premiums and those who are at risk of being disenrolled for non-payment of premiums, as well as those who are disenrolled for non-payment. We have found that the percentage of clients who are disenrolled for non-payment of premiums is very low. The low cost of $10 per month per child with a family maximum of $30 per month does not seem to be cost prohibitive for our SCHIP households. In the past year, the percentage of households with any overdue premium (30, 60, 90 or 120 days) averaged15.6%. The percentage of households who were at least 90 days overdue and at risk of being disenrolled for non-payment averaged 3.5%. The percentage of households who became 4 months overdue and were disenrolled averaged just under 0.8% per month. The table below reflects this information.

MONTH	Number of Households Billed	% Households with Overdue Premium (any amount)	% Households 90 days Overdue	% Households Disenrolled for 4-months Overdue
October 2002	3977	17.5	6.8	0.7
November 2002	4097	15.7	6.4	1.5
December 2002	4161	17.7	639	0.4
January 2003	4117	14.6	2.6	0.8
February 2003	4120	16.5	3.1	1.3
March 2003	4148	14.3	2.3	1.0
April 2003	3998	15.9	2.3	0.5
May 2003	4003	15.8	2.1	0.5

June 2003	4040	15.2	1.9	0.5
July 2003	4100	15.1	2.5	0.6
August 2003	4142	14.6	2.6	0.9
September 2003	4262	14.1	2.0	0.6
Average	**4,097**	**15.6%**	**3.5%**	**0.78%**

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

We have not undertaken an assessment of the effects of cost sharing on utilization of health services by SCHIP clients.

Premiums were required when we implemented SCHIP. We do not have a period of time without cost-sharing to conduct a pre-premium/post-premium analysis.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

__X__ No, skip to Section IV.

____ Yes, Check all that apply and complete each question for each authority.
____ State plan
____ Family Coverage
____ Section 1115 Demonstration
____ Health Insurance Accountability &Flexibility Demonstration
____ HIPP

2. Briefly describe your program (including current status, progress, difficulties, etc.)

3. What benefit package does the program use?

4. Does the program provide wrap-around coverage for benefits or cost sharing?

5. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever enrolled during the reporting period
_____ Number of children ever enrolled during the reporting period

6. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

7. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

8. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. (*Note: This reporting period = Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments			
Managed Care	6,318,059	7,828,548	8,915,188
Per member/Per month rate @ # of eligibles	$66.72	$72.09	$75.24
Fee for Service	4,488,857	6,179,915	6,682,417
Total Benefit Costs	**10,806,916**	**14,008,463**	**15,597,615**
(Offsetting beneficiary cost sharing payments)	777,670	941,962	1,030,050
Net Benefit Costs	**$10,029,246**	**$13,066,501**	**$14,567,565**

Administration Costs			
Personnel	108,651	114,083	119,787
General Administration	13,004	13,654	14,336
Contractors/Brokers (e.g., enrollment contractors)	220,243	231,255	242,818
Claims Processing	21,896	22,991	24,141
Outreach/Marketing costs	105,072	110,326	115,842
Other			
Total Administration Costs	**468,865**	**492,309**	**516,925**
10% Administrative Cap (net benefit costs ÷ 9)	**1,114,361**	**1,451,833**	**1,618,618**

Federal Title XXI Share	**6,823,772**	**8,813,227**	**9,804,919**
State Share	**3,674,339**	**4,745,584**	**5,279,572**

TOTAL COSTS OF APPROVED SCHIP PLAN	**10,498,111**	**13,558,810**	**15,084,490**

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- _____ County/local funds
- _____ Employer contributions
- _____ Foundation grants
- _____ Private donations (such as United Way, sponsorship)
- _____ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period	Next Fiscal Year	Following Fiscal Year
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			

Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			

Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			

Administration Costs

Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			

Federal Title XXI Share			
State Share			

TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

Over the past reporting period, Washington State continued to deal with economic and budget concerns. During our most recent Legislative session, our Legislature had to contend with the issue of healthcare costs. They struggled with ways to keep as many services as possible available to our low-income population. In response to this challenge, they made two changes that affect our medical population, including the SCHIP population.

One is the change from 12 months of continuous eligibility to a 6-month eligibility period. The other change is that declaration of income is no longer accepted; income documentation is required on all cases.

As these changes were only recently implemented, we do not yet have data on what the effects on the SCHIP population will be. We anticipate we will have data to report in our 2004 Annual Report.

2. During the reporting period, what has been the greatest challenge your program has experienced?

One of our greatest challenges remains the economy of the state and the fact that we were unable to utilize all the appropriated SCHIP funds.

The economy of the state has contributed towards the rising number of uninsured children in the SCHIP population. We continue to work towards enrolling the remainder of the eligible SCHIP population. Though our enrollment numbers have continued to increase, there are still eligible children not yet enrolled in the program. We are fortunate to have the support of our community partners and advocates in finding and assisting this population.

3. During the reporting period, what accomplishments have been achieved in your program?

A major accomplishment is that we continued to increase our enrollment in the program. SCHIP enrollment increased from 7,114 children on September 30, 2002, to 8,012 children on September 30, 2003. This is almost a 12% increase.

Our amendment for pre-natal coverage for unborn children was approved by CMS in September 2003. We will have data available on this population in our 2004 Annual Report.

We also made an improvement to our eligibility review forms as they are now pre-populated with information making it easier for our clients to review and complete.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

We currently have an 1115 Waiver Request pending at CMS that would allow premiums for optional Medicaid children. In the 2003 Legislative session, our state Legislature mandated that DSHS pursue approval of the waiver. They also approved the creation of premium “bands” for optional children and included a “Band C” for SCHIP children. In the 2003-05 Biennial Budget Detailed Notes, the premium amount to be charged to SCHIP clients is $25 per month; an increase from the current $10 per month. We anticipate that there will be a change in the premium amount for the SCHIP population during the next fiscal year, though the amount of the increase is not yet known.